WIC PROGRAM
MEDICAL INFORMATION FORM FOR WOMEN'S HEALTHCARE PROVIDERS

WIC ID#

Note to Health Care Provider:

Please print out this form, complete it and give it back to your patient to return to WIC.

PATIENT INFORMATION

Date of Birth:
Parent/Gaurdian Name:

ALL WOMEN

Date Collected / /	Date Collected / /
Weight	Hgb
Length/Height	Hct

PREGNANT WOMEN

EDD
Pregravid Weight

POSTPARTUM WOMEN

Weight at pregnancy end

HEALTH/MEDICAL CONCERNS and RISK FACTORS

PATIENT'S HEALTH CARE PROVIDER

Provider Name	
Signature	Date / /
Address	Phone ( ) -

State of Rhode Island
Department of Health
Rhode Island WIC Program
www.health.ri.gov/family/wic

grow with WIC

MAKE HEALTH PART OF YOUR FAMILY
RHODE ISLAND DEPARTMENT OF HEALTH